City of Seattle -– Retirees Under Age 65
2004 Summary of Benefits

Group Health Cooperative (GHC)		City of Seattle Traditional Plan		City of Seattle Preventive Plan	
Standard Plan	**Deductible Plan**	**Aetna In-Network**	**Out-of-Network**	**Aetna In-Network**	**Out-of-Network**
Deductible (per calendar year)					
Does not apply	$200 per person $600 per family Except as noted, deductible applies to all services except prescriptions, preventive care visits, ambulance service and durable medical equipment.	$500 per person $1,500 per family Except as noted, deductible applies to most services. Deductible does not apply for prescriptions or when the Inpatient copay or emergency room copay applies.	$1,000 per person $3,000 per family	$150 per person $450 per family Except as noted, deductible applies to most services. Deductible does not apply for prescriptions or when the physician's office visit copay, inpatient copay or emergency room copay applies.	$450 per person $1,350 per family
Annual Out of Pocket (OOP) Maximum* (excluding deductible if applicable) Aetna Copays do not apply towards OOP					
$2,000 per person $4,000 per family	$2,000 per person $4,000 per family	$1,000 per person $3,000 per family Most costs paid at 100% of R & C* after out-of-pocket maximum is paid.	$2,000 per person $6,000 per family.	$2,000 per person $4,000 per family	$3,000 per person $6,000 per family Most costs paid at 100% of R & C* after out-of-pocket maximum is paid.
Maximum Lifetime Benefits Payable					
Does not apply	Does not apply	$1,000,000		Unlimited	$1,000,000
Inpatient Copay					
$100 per day for the first four days.	Does not apply	80% after $400 copay per admission.	60% after $400 copay per admission.	90% after $400 copay per admission.	60% after $400 copay per admission.
Inpatient Pre-admission Authorization					
Except for maternity or emergency admissions, must be authorized by GHC	Except for maternity or emergency admissions, must be authorized by GHC	Except for maternity or emergency admissions, your physician must contact Aetna prior to your admission		Except for maternity or emergency admissions, your physician must contact Aetna prior to your admission	
Choice of Providers					
All care and services must be approved and/or provided by GHC or GHC designated providers. Members may self-refer to specialists at GHC facilities.	All care and services must be approved and/or provided by GHC or GHC designated providers. Members may self-refer to specialists at GHC facilities.	Any Aetna contracted provider member. No primary care physician selection required. No referrals required. Aexcel Specialists^ must be used to receive highest level of benefits.	Any licensed, qualified provider of your choice. Expenses paid based on Reasonable & Customary (R&C)* charges. You pay the difference between R&C and billed charges.	Any Aetna contracted provider member. No primary care physician selection required. No referrals required. Aexcel Specialists^ must be used to receive highest level of benefits.	Any licensed, qualified provider of your choice. Expenses paid based on Reasonable & Customary (R&C)* charges. You pay the difference between R&C and billed charges.
COVERED EXPENSES					
Acupuncture					
Paid at 100% after $20 copay. Five visits per condition per year self-referred. Additional visits for certain conditions when physician authorized.	Paid at 100% after $20 copay. Five visits per condition per year self-referred. Additional visits for certain conditions when physician authorized.	Paid at 80% Maximum of 12 visits per calendar year for in-network and out-of-network combined. Maximum does not include acupuncture treatment for chemical dependency.	Paid at 60%	Paid at 100% after $20 copay	Paid at 60%

Group Health Cooperative (GHC)		City of Seattle Traditional Plan		City of Seattle Preventive Plan	
Standard Plan	**Deductible Plan**	**Aetna In-Network**	**Out-of-Network**	**Aetna In-Network**	**Out-of-Network**
Ambulance Service					
Paid at 80%. GHC-initiated non-emergency transfers are paid at 100%	Paid at 80%. GHC-initiated non-emergency transfers are paid at 100%	Paid at 80% when medically necessary. Non-emergency transportation must be approved in advance by Aetna.		Paid at 90% when medically necessary. Non-emergency transportation must be approved in advance by Aetna.	
Chemical Dependency Treatment (alcohol/drug addiction)					
Inpatient: Paid at 100% after $100 copay per day for the first four days.	In patient: Paid at 100%	Inpatient: Paid at 80% after $400 copay	Inpatient: Paid at 60% after $400 copay	Inpatient: Paid at 90% after $400 copay	Inpatient: Paid at 60% after $400 copay
Outpatient: Paid at 100% after $20 copay	Outpatient: Paid at 100% after $20 copay.	Outpatient: Paid at 80%	Outpatient: Paid at 60%	Outpatient: Paid at 100% after $20 copay	Outpatient: Paid at 60%
Combined benefit maximum of $11,841 per 24 month period for inpatient and outpatient services	Combined benefit maximum of $11,841 per 24 month period for inpatient and outpatient services	Combined benefit maximum of $11,841 per 24 month period for in-network and out-of-network services		Combined benefit maximum of $11,841 per 24 month period for in-network and out-of-network services	
Contraceptives					
Contraceptive drugs and devices see Prescription Drug benefit.	Contraceptive drugs and devices see Prescription Drug benefit.	See Prescription Drug benefit. IUDs and Depo Provera are covered as medical benefits.	Prescription contraceptive products are not covered. IUDs and Depo Provera are covered as medical benefits.	See Prescription Drug benefit. IUDs and Depo Provera are covered as medical benefits.	Prescription contraceptive products are not covered. IUDs and Depo Provera are covered as medical benefits.
Durable Medical Equipment					
Paid at 80%	Paid at 80%	Paid at 80% Maximum benefit of $5,000 per calendar year for in-network and out-of-network combined.	Paid at 60%	Paid at 90% Maximum benefit of $5,000 per calendar year for in-network and out-of-network combined.	Paid at 60%
Emergency Room Services					
GHC facility: Paid at 100% after $100 copay (waived if admitted) Non-GHC facility: Paid at 100% after $150 copay	GHC facility: Paid at 100% after $75 copay (waived if admitted) Non-GHC facility: Paid at 100% after $125 copay	Paid at 80% after $150 copay (waived if admitted)	Paid the same as in network, except if it's non-emergency use, then 60% after $150 copay (waived if admitted).	Paid at 90% after $150 copay (waived if admitted)	Paid the same as in network, except if it's non-emergency use, then 60% after $150 copay (waived if admitted).
Home Health Care					
Paid at 100% when authorized	Paid at 100% when authorized	Paid at 80% Maximum benefit of 130 visits per calendar year for in-network and out-of-network combined.	Paid at 60%	Paid at 90% Maximum benefit of 130 visits per calendar year for in-network and out-of-network combined.	Paid at 60%
Hospice					
Paid at 100% when authorized	Paid at 100% when authorized	Paid at 80% Lifetime maximum of 6 months or $10,000, whichever is greater. 14-day inpatient limit. 120-hour outpatient limit.	Paid at 60%	Paid at 90% Maximum of 6 months for inpatient and outpatient combined.	Not covered.

Maternity Care (delivery & related hospital)					
Paid at 100% after $100 copay per day for the first four days	Paid at 100%	Paid at 80% after $400 copay	Paid at 60% after $400 copay	Paid at 90% after $400 copay	Paid at 60% after $400 copay
Maternity Care (prenatal and postpartum)					
Paid at 100% after $20 copay	Paid at 100% after $20 copay	Paid at 80%	Paid at 60%	Paid at 100% after $20 copay	Paid at 60%
Mental Health Care (inpatient)					
Paid at 80% after $100 copay per day for the first four days	Paid at 80%	Paid at 80% after $400 copay	Paid at 60% after $400 copay	Paid at 90% after $400 copay	Paid at 60% after $400 copay
Maximum of 12 days per calendar year	Maximum of 12 days per calendar year	Maximum of 8 days per calendar year for in-network and out-of-network combined		Maximum of 30 days per calendar year for in-network and out-of-network combined	
Mental Health Care (outpatient)					
Paid at 100% after a $20 copay per individual, family or couple session or $10 copay per group therapy visit. Copays do not apply to the out-of-pocket maximum	Paid at 100% after $30 copay per individual, family or couple session or $20 copay per group therapy visit. Copays do not apply to the out-of-pocket maximum	Paid at 80% Coinsurance does not apply to the annual out-of-pocket maximum		Paid at 100% after $20 copay.	Paid at 60% Coinsurance applies to the annual out-of-pocket maximum.
Maximum of 20 visits per calendar year.	Maximum of 20 visits per calendar year.	Maximum of 12 visits per calendar year for in-network and out-of-network combined.		Maximum of 20 visits per calendar year for in-network and out-of-network combined.	
Neurodevelopmental Therapy (for children 6 and under)					
Covered under Rehabilitation benefit.	Covered under Rehabilitation benefit.	Outpatient: Paid at 80%.	Outpatient: Paid at 60% .	Outpatient: Paid at 100% after $20 copay.	Outpatient: Paid at 60% Coinsurance applies to the annual out-of-pocket maximum.
		Maximum of $2,000 per calendar year. Coinsurance does not apply to the out-of-pocket maximum.		Maximum of $3,000 per calendar year for in-network and out-of-network combined.	
Physician and Hospital Services					
Inpatient: Paid at 100% after $100 copay per day for the first four days.	Inpatient: Paid at 100%	Inpatient: Paid at 80% after $400 copay per admission. Aexcel Specialists^ must be used to receive highest level of benefits.	Inpatient: Paid at 60% after $400 copay per admission.	Inpatient: Paid at 90% after $400 copay per admission. Aexcel Specialists^ must be used to receive highest level of benefits.	Inpatient: Paid at 60% after $400 copay per admission
Outpatient: Paid at 100% after $20 copay for most visits	Outpatient: Paid at 100% after $20 copay for most visits	Outpatient: Paid at 80%	Outpatient: Paid at 60%	Outpatient: Physician services paid at 100% after $20 copay per visit. Outpatient procedure at a hospital paid at 90%.	Outpatient: Paid at 60%

Prescription Drugs (retail)					
For a 30 day supply: **Generic**: $15 copay **Brand:** $30 copay Contraceptive drugs and devices are covered subject to the pharmacy copay. Copays do not apply to the annual out-of-pocket maximum.	**For a 30-day supply:** **Generic**: $15 copay **Brand:** $30 copay Contraceptive drugs and devices are covered subject to the pharmacy copay. Copays do not apply to the annual out-of-pocket maximum.	For a 34-day supply: **Generic**: 30% copay. Some generic maintenance drugs dispensed as greater of 34-day supply or 100 units. **Preferred brand name**: 50% copay **Non-preferred drugs**: 50% copay Oral contraceptive products are covered. (IUDs and Depro Provera are covered under the medical plan benefit.) Copays apply to the prescription $1,500 out-of-pocket annual maximum per person. The copay is a $10 minimum or actual cost of the drug if less, or $100 maximum charge.	Not covered	For a 31-day supply: **Generic**: 30% copay **Preferred brand name**: 50% copay **Non-preferred drugs**: 50% copay Oral contraceptive products are covered. (IUDs and Depro Provera are covered under the medical plan benefit.) Copays apply to the prescription $1,500 out-of-pocket annual maximum per person. The copay is a $10 minimum or actual cost of the drug if less, or $100 maximum charge.	Not covered
Prescription Drugs (mail order)					
For a 30 day supply: **Generic**: $15 copay **Brand:** $30 copay Contraceptive drugs and devices are covered subject to the pharmacy copay. Copays do not apply to the annual out-of-pocket maximum.	For a 90 day supply: **Generic**: $30 copay **Brand:** $60 copay Contraceptive drugs and devices are covered subject to the pharmacy copay. Copays do not apply to the annual out-of-pocket maximum.	For a 90-day supply: **Generic**: 30% copay **Preferred brand name**: 50% copay **Non-preferred drugs**: 50% copay. **The copay is $20 or double the cost of the drug if less or $200 maximum charge.**	Not Covered	For a 90-day supply: **Generic**: 30% copay **Preferred brand name**: 50% copay **Non-preferred drugs**: 50% copay. **The copay is $20 or double the cost of the drug if less or $200 maximum charge.**	Not Covered
Preventive Care					
Paid at 100% after $20 copay for preventive care visits, most immunizations, hearing exams, eye exams and mammograms.	Paid at 100% after $20 copay. Preventive care visits, most immunizations, eye exams and mammograms not subject to the deductible. Hearing exams are subject to the deductible..	Mammograms paid at 80%. No other preventive services are covered	Mammograms paid at 60%	Paid at 100% (copay waived) for periodic check-ups, well child care, immunizations, well woman care and mammograms.	Paid at 60% for well woman care and mammograms. No other preventive services covered.

Rehabilitation Services (inpatient)					
Paid at 100% after $100 copay per day for the first four days. Maximum of 60 days per condition per calendar year.	Paid at 100% Maximum of 60 days per condition per calendar year.	Paid at 80% after $400 copay Maximum of $50,000 per condition for in-network and out-of-network combined.	Paid at 60% after $400 copay	Paid at 90% after $400 copay Maximum of 120 days per calendar year for in-network and out-of-network combined.	Paid at 60% after $400 copay
Rehabilitation Services (outpatient)					
Paid at 100% after $20 copay Maximum of 60 visits per condition per calendar year	Paid at 100% after $20 copay Maximum of 60 visits per condition per calendar year	Paid at 80% Coinsurance does not apply to the annual out-of-pocket maximum. Benefit includes physical/massage, speech, occupational and cardiac/pulmonary therapy. Maximum calendar year benefit of $2,000 for in-network and out-of-network combined.	Paid at 60%	Paid at 100% after $20 copay Benefit includes physical/massage, speech, occupational and cardiac/pulmonary therapy. Maximum of 20 visits for each of the above listed benefits per calendar year for in-network and out-of-network combined.	Paid at 60%
Skilled Nursing Facility					
Paid at 100%; 60 day maximum per calendar year (in addition to coverage in lieu of hospitalization).	Paid at 100%; 60 day maximum per calendar year (in addition to coverage in lieu of hospitalization).	Paid at 80% after $400 copay Maximum of 90 days per calendar year for in-network and out-of-network combined.	Paid at 60% after $400 copay	Paid at 90% after $400 copay Maximum of 120 days per calendar year for in-network and out-of-network combined.	Paid at 60% after $400 copay
Smoking Cessation					
Paid at 100% for individual/group sessions. Nicotine replacement therapy included in Prescription Drugs benefit.	Paid at 100% for individual/group sessions. Nicotine replacement therapy included in Prescription Drugs benefit.	Lifetime maximum of one 90-day supply of smoking cessation aids or drugs. See Prescription Drugs; retail.	Not covered	Not covered	
Spinal Manipulations					
Paid at 100% after $20 copay. Self-referral to GHC designated providers. Must meet GHC protocol. Maximum of 10 visits per calendar year.	Paid at 100% after $20 copay. Self-referral to GHC designated providers. Must meet GHC protocol. Maximum of 10 visits per calendar year.	Paid at 80% Maximum of 10 visits per calendar year for in-network and out-of-network combined.	Paid at 60%	Paid at 100% after $20 copay. Maximum of 20 visits per calendar year for in-network and out-of-network combined.	Paid at 60%
Sterilization Procedures					
Not covered	Not covered	Inpatient: Paid at 80% after $400 copay Outpatient: Paid at 80%.	Inpatient: Paid at 60% after $400 copay Outpatient: Paid at 60%	Inpatient: Paid at 90% after $400 copay Outpatient Surgery: Paid at 90%	Inpatient: Paid at 60% after $400 copay Outpatient Surgery: Paid at 60%

Temporomandibular Joint (TMJ) Services					
Inpatient: Paid at 100% after $100 copay per day for the first four days. Outpatient: Paid at 100% after $20 copay Maximum benefit of $1,000 per calendar year/$5,000 lifetime for inpatient and outpatient combined.	Inpatient: Paid at 100% Outpatient: Paid at 100% after $20 copay Maximum benefit of $1,000 per calendar year/$5,000 lifetime for inpatient and outpatient combined.	Not covered		Not covered	
Tooth Injury due to accident					
Not covered	Not covered	Inpatient: Paid at 80% after $400 copay	Inpatient: Paid at 60% after $400 copay	Inpatient: Paid at 90% after $400 copay	Inpatient: Paid at 60% after $400 copay
		Outpatient: Paid at 80% Services of dentist or denturist covered based on R&C charges up to 12 months from injury date to a maximum of $600. Physician and hospital benefits provided if inpatient care needed.	Outpatient: Paid at 60%	Outpatient: Paid at 100% after $20 copay. Services of dentist or denturist covered based on R&C charges up to 12 months from injury date. Physician and hospital benefits provided if inpatient care needed.	Outpatient: Paid at 60%
Travel Outside of Country					
Emergency: Paid at 100% after $150 deductible Non-emergency: Not covered	Emergency: Paid at 100% after $125 deductible Non-emergency: Not covered	Not applicable	Paid at 80% after applicable office, emergency room or hospital copay for an emergency. Paid at 60% after applicable copay for non-emergency.	Not applicable	Paid at 100% after applicable office, emergency room or hospital copay. Paid at 60% after applicable copay for non-emergency.
Vision Exam and Hardware					
Exam: Paid at 100% after $20 copay at GHC. Hardware: Not covered.	Exam: Paid at 100% after $20 copay at GHC. Hardware: Not covered.	Exam: Paid at 100%. Hardware: Two lenses per calendar year; $20-$40 per lens. Additional coverage for special eye conditions. Frames: $30 every other year.		Not covered	
X-ray and Lab Tests					
Paid at 100%	Paid at 100%	Paid at 80%	Paid at 60%	Paid at 90% (except covered at 100% if associated with routine physical exam benefit)	Paid at 60%

*Applies to Aetna - Reasonable & Customary (R & C) - charges are the lower of the provider's usual charge for performing a service, and the charge that is determined to be the prevailing fee in the geographic area where the service is provided. The charge is determined by looking at other providers' charges in the same geographical area.

^Applies to Aetna – Aexcel network, a specialty network of doctors in the areas of cardiology, gynecology/obstetrics, gastroenterology, cardio-thoracic surgery, general surgery and orthopedic surgery. The coinsurance level will drop 10% for non-Aexcel doctors in the six specialty areas (coinsurance applies to in-network, out-of-pocket maximum).

This summary is intended to assist you in decision making. Details of covered benefit limitations and exclusions are provided in your benefit booklet. This summary is not a contract.